MICHIGAN Primary Care ASSOCIATION

Testimony before the Senate Appropriations Committee

Presented on behalf of
The Michigan Primary Care Association
By
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Good afternoon Chairman Kahn and members of the committee. My name is Doug Paterson and am here today representing the 35 Federally Qualified Health Center organizations making up the Michigan Primary Care Association. Collectively, our member organizations operate 220 community health center sites throughout Michigan. Every one of them is located in an officially recognized medically underserved area or serves a designated medically underserved population. We are an important part of the "safety net" that attempts to assure our State's residents, especially those without insurance, those with Medicaid and those in Medically Underserved areas of our state, have access to medical, dental and behavioral health services.

I am here today to convey the support of our organization for Senate Bill 1359.

It is our understanding from the State Budget office that as they monitor revenue from the health insurance claims assessment, significant shortages are occurring. Our further understanding is that IF forced to address this shortfall without a revenue solution, the only option is the reduction of provider rates. Reduction in benefits or eligibility categories, the only other options to reduce Medicaid costs, are prohibited by the Affordable Care Act.

Unlike most providers of primary care in our state, our members cannot and do not deny access to medical or dental care to anyone who crosses our threshold. Once you enter the door of an FQHC, you are a patient for life, if you so desire, regardless of income, insurance coverage or ability to pay. We are unique in this commitment. However, our capacity to fill this need is limited. We, and the residents of this state, depend upon private sector physicians and dentists to meet some of the demand for services, especially service to those on Medicaid, as we would be totally incapable of meeting the demand if more and more of this population needed service from us. Any policy that encourages the reduction of service to the Medicaid population by the private sector has a major impact upon our network and upon the ability of thousands of Michigan residents to receive care.

It might appear to many that we have a selfish motive in our support of this bill, as it would affect the rates we are paid by Medicaid. This, in fact, is not true. FQHC's are guaranteed reimbursement of our costs in federal statute, so we are not at economic risk if a revenue solution is not forthcoming. However, our mission is compromised since we exist solely for the purpose of assuring access to needed care to all our state's residents. We will not be able to achieve our mission, without partnership and participation of the private sector.

As you know, we all spend a considerable amount of time involved in discussions related to insurance coverage. However, I need to point out a very real fact that insurance coverage does not translate into access to care. If a person has insurance coverage of some kind, it

does not mean they are able to find a provider who will accept that insurance and provide them care. This is especially true related to Medicaid.

You have repeatedly heard from Michigan's physician provider organizations that Medicaid reimbursement is insufficient to cover the cost of providing care to this population. It seems rational that if there is a decrease in the cost reimbursement for Medicaid services, there will be a concurrent increase in the number of providers who make the rational economic decision to discontinue services to the Medicaid population.

The assumptions made in the 2012 budget that the health insurance claims assessment, established at 1% would generate $400 million in revenue, have proven inaccurate. It appears that the numbers of claims paid for policies issued out of state, claims related to self-funded insurance, and the massive increase of high deductible policies, that reduce the number of claims made, were significantly underestimated. This was not foreseen. In fact, there were discussions during debate on the original bills, about the potential generation of more than $400 million from this assessment and provisions were included in the original bill to address this possibility. There was some brief discussion at that time about the possibility of underfunding, but this was dismissed due to the fact that it wasn't considered a possibility. In hind sight, if the original bill had started with the assumption that $400 million was needed, and had built in a mechanism such as is being proposed by SB 1359, we wouldn't be facing the current problem.

One argument being made is that if the rate charged became variable, it would open up the possibility of even higher rates in the future. We would argue that building in the cap of $400 million of needed revenue mitigates this concern. All the variable rate does is assure that the original amount upon which the budget is built is available. If, in fact, more than $400 million is captured, then the rate actually could be lowered. This seems a very reasonable solution. What this solution does, is simply eliminate the variation in the formula caused by an indeterminate number of claims that will be filed. The amount collected will be the same and not dependent upon the numbers or amounts of claims.

We are supportive of this bill because it is the only solution to date that has been offered. If, out of these discussions other solutions are proposed, we would likely support them as well IF the outcome was to assure that cuts to provider rates would not be necessary. However, if this body feels that the insurance claims assessment is the correct mechanism to use, as the original bill established, then this bill seems to correct the inaccurate assumptions that were made at that time and seems reasonable.

Thank you Senator Kahn for this opportunity to express our views!